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In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

OHIO STATE UNIVERSITY, D/B/A OHIO STATE HOSPITALS

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

Under Medicare regulations, the cost of training programs for interns and residents (known as graduate medical education, or GME, programs) is an "allowable cost" for which a hospital may receive reimbursement. 42 C.F.R. 413.85(a). Reimbursement is not available, however, for any "increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

The issue presented is:

Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars a hospital providing Medicare services from obtaining reimbursement of otherwise reimbursable GME program costs that previously were absorbed by its affiliated medical school.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statutory and regulatory provisions involved	2
Statement	2
Reasons for granting the petition	7
Conclusion	9
Appendix A	1a
Appendix B	7a
Appendix C	27a
Appendix D	29a

TABLE OF AUTHORITIES

Statutes and regulations:	
Social Security Act, Tit. XVIII, 42 U.S.C. 1395 *et seq.* (1976)	2
42 U.S.C. 1395k	2
42 U.S.C. 1395*l*	2
42 U.S.C. 1395x(s)	2
42 U.S.C. 1395x(v)	2
42 U.S.C. 1395x(v)(1)(A)	2, 29a
42 U.S.C. 1395hh	2
42 U.S.C. 1395ww(h)	4
Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 331	3
42 C.F.R.:	
Section 413.17(a)	2, 32a
Section 413.85(a)	2, 3, 30a
Section 413.85(b)	3
Section 413.85(c)	2, 3, 6, 7, 31a
Section 413.85(g)	2, 31a
Section 413.86(e)(1)(A)	4

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-6a), is reported at 996 F.2d 122. The opinion of the district court (App., *infra*, 7a-26a) is reported at 777 F. Supp. 582.

JURISDICTION

The judgment of the court of appeals was entered on June 8, 1993. A timely petition for rehearing was denied on August 4, 1993. App., *infra*, 27a-28a. The Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant statutory section, 42 U.S.C. 1395x(v)(1)(A), and regulations, 42 C.F.R. 413.85(a), (c), and (g), and 42 C.F.R. 413.17(a), are set forth at App., *infra*, 29a-32a.

STATEMENT

1. This case involves the application of a regulation prohibiting Medicare reimbursement to patient care institutions, such as hospitals, of "redistribut[ed] costs" that are incurred in connection with a hospital's graduate medical education (GME) program.

In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for inpatient hospital and related post-hospital services.[1] From 1966 through 1982, "providers of services" under Part A generally were reimbursed for reasonable and necessary costs, both direct and indirect, related to Medicare-covered patient care. The reasonable cost calculation was based on necessary "cost[s] actually incurred." 42 U.S.C. 1395x(v). The Secretary was authorized to issue regulations defining the reimbursement that is due under this statutory standard. 42 U.S.C. 1395hh, 1395x(v)(1)(A).

Under Medicare regulations, the costs of certain educational programs for health professional trainees—including programs for interns and residents

[1] Part B is a voluntary supplementary insurance program covering physicians' charges and other medical services. 42 U.S.C. 1395k, 1395*l*, and 1395x(s).

known as graduate medical education (GME) programs—are "allowable cost[s]" for which a hospital may receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a). The category of reimbursable costs includes direct and overhead costs, and it encompasses expenses incurred by the hospital as well as by the hospital's affiliated medical school in connection with the hospital's GME program for trainees who provide patient care services in the hospital, 42 C.F.R. 413.85(b).[2] Under the governing regulations, however, GME costs are reimbursable only if they do not represent costs that have been redistributed from educational to patient care institutions. 42 C.F.R. 413.85(c).[3] In the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 331, Congress changed the method of calculating Medicare reimbursement by creating the Prospective Payment System (PPS), which establishes fixed payment rates for various services associated with the inpatient care of program beneficiaries. Costs incurred in connection with GME programs were excluded from the PPS scheme, and continued to be reimbursed under the old "reasonable cost" system. In the same enactment, however, Congress did make

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[2] For example, the amounts in dispute in this case included "the cost of space, salaries, utilities, supplies, etc. which were related to patient services." App., *infra*, 2a.

[3] That regulation provides, in pertinent part:

> Although the intent of the [Medicare] program is to share in the support of educational activities customarily or traditionally carried on by providers * * *, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

a change in the method for reimbursing GME costs by providing that, subject to appropriate updating, the calculation of GME costs to be reimbursed in all subsequent years would be based on the amount of GME costs claimed by the provider for a fiscal year that begins between October 1, 1983 and September 30, 1984 (the base year). 42 U.S.C. 1395ww(h); 42 C.F.R. 413.86(e)(1)(A).

2. Ohio State University Hospitals (the Provider) operates a teaching hospital that is a separate administrative division of the Ohio State University. App., *infra,* 7a. The Provider operates a Medicare-approved GME program for interns and residents. *Id.* at 7a-8a. The GME program is administered by the University's medical school, the Ohio State College of Medicine. *Id.* at 8a-9a.

Since the Medicare program's inception, the Provider had claimed and received reimbursement for certain direct costs related to the GME program. App., *infra,* 8a. For its 1985 fiscal year, however, the Provider also included in its Medicare claim indirect costs (overhead or general administrative (G&A) costs) related to its GME program, for which it requested reimbursement in the amount of $765,000. *Id.* at 8a-9a.

3. The fiscal intermediary responsible for determining the Provider's allowable costs denied reimbursement for the new GME-related costs that were claimed for fiscal 1985. App., *infra,* 8a-9a. On appeal, the Provider Reimbursement Review Board (PRRB) reversed the intermediary's decision and allowed reimbursement of the new costs. *Id.* at 9a. The Administrator of the Health Care Financing Administration (acting for the Secretary) reversed the PRRB's deci-

sion. *Ibid.* He concluded that the indirect costs were not allowable and "that reimbursement would violate the Secretary's regulation against redistribution of the costs of an educational institution, 42 C.F.R. § 413.85(c)." *Id.* at 9a-10a.

4. The district court set aside the Secretary's decision. App., *infra*, 7a-26a. The district court noted that the Administrator's denial of reimbursement to the Provider for newly claimed GME-related costs was based on the Provider's failure to show that it had "historically incurred, paid and reported" the costs. *Id.* at 15a.[4] The court held that where the educational activity itself is "customarily or traditionally carried on by providers in conjunction with their operations" (*id.* at 16a), it does not matter whether the provider or the medical school has historically paid the resulting costs. Instead, the court concluded, the prohibition against redistribution of costs was "intended to guard against a situation in which a provider would undertake educational activities"—including "non-clinical educational activities, such as undergraduate instruction * * * customarily and traditionally carried on by educational institutions but not cus-

[4] With regard to the question of who had previously absorbed the GME-related costs newly claimed by the Provider in this case, the district court quoted the decision of the Administrator, which noted the Provider's representation that "these costs have been absorbed by the Provider *and* the [medical school]." App., *infra*, 15a. The Administrator found nothing in the record to indicate that any of the costs in issue were directly "incurred or reported by the Provider in prior years." *Ibid.* The district court did find evidence, however, that the Provider had historically transferred funds to the medical school to offset some (but not all) of the medical school's costs of providing services to the hospital's GME programs. *Id.* at 12a.

tomarily and traditionally carried on by patient care institutions"—and "ask the Medicare program to participate in such increased costs." *Id.* at 18a-19a. The court further stated that "the underlying purpose of the redistribution principle is to limit reimbursement to educational costs related to patient care and to deny reimbursement for educational costs unrelated to patient care." *Id.* at 19a. The court found no evidence of such unrelated costs in the present case. *Ibid.*[5]

5. The court of appeals affirmed.[6] App., *infra*, 6a. The court held that the Secretary's interpretation of the anti-redistribution regulation "is neither reasonable nor persuasive because it does not comport with the language of 42 C.F.R. § 413.85(c)." *Id.* at 5a. The court held that, even where the disputed GME costs previously had been borne by the medical school, reimbursement of those costs would not violate the prohibition against redistribution in 42 C.F.R. 413.85(c), as long as the costs were related to patient care. App., *infra*, 6a. The court construed the proscription against redistribution as not applying to "educational activities customarily and traditionally carried on by providers in conjunction with" patient care activities, but as covering only "redistribution of costs from an educational program, such as classroom expenses, to a provider of Medicare medical services." *Ibid.*

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[5] The court also rejected the Administrator's determination that the indirect GME-related costs were not allowable costs under the Medicare Act. App., *infra*, 20a-25a. That ruling is not at issue here.

[6] Judge Boggs concurred only in the result. App., *infra*, 6a.

REASONS FOR GRANTING THE PETITION

This Court has pending before it a petition for a writ of certiorari in *Thomas Jefferson University d/b/a Thomas Jefferson University Hospital* v. *Shalala*, No. 93-120 (filed July 20, 1993), which raises the same question presented in this case. Like *Jefferson University*, this case involves the application of the anti-redistribution regulation, 42 C.F.R. 413.85(c), which prohibits Medicare reimbursement to patient care institutions, such as hospitals, of educational and training costs related to patient care that have been "redistribut[ed] * * * from educational institutions or units to patient care institutions or units." The question presented in both cases is whether the Secretary of Health and Human Services reasonably interpreted the regulation as barring reimbursement to a hospital of GME-related costs that in previous years had been absorbed by the hospital's affiliated medical school, but are now being claimed by the hospital for reimbursement under Medicare.[7] In *Jefferson University*, the Third Circuit affirmed a district court decision sustaining the Secretary's interpretation of the anti-redistribution regulation and denying reimbursement to a university hospital for GME-related costs that had previously been absorbed by its affiliated medical school. Contrary to the holding in *Jefferson University*, the Sixth Circuit in this

[7] Although the district court noted that the provider in this case had in the past paid the medical school for some of the GME-related services the medical school provided, most GME-related costs claimed by the provider for services rendered by the medical school were not reimbursed, but were absorbed directly by the medical school. See App., *infra*, 15a (claimed GME overhead costs "have been absorbed by the Provider *and* the [medical school]).

case construed the anti-redistribution regulation as permitting a provider to claim reimbursement of all GME-related expenses, regardless of whether the costs had previously been claimed or paid by the provider, as long as the costs were related to patient care.

In light of the square circuit conflict and the recurring importance of the legal issue, we have filed a response to the certiorari petition in *Jefferson University* urging the court to grant review in that case. If the Court grants certiorari in *Jefferson University*, its decision on the merits would affect the outcome of this case. The Court should therefore hold the petition in this case and then dispose of it as appropriate in light of the disposition of the petition and any decision on the merits in *Jefferson University*.

CONCLUSION

The petition for a writ of certiorari should be held and disposed of in light of the Court's disposition of *Thomas Jefferson University d/b/a Thomas Jefferson University Hospital* v. *Shalala*, petition for certiorari pending, No. 93-120.

Respectfully submitted.

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NOVEMBER 1993

APPENDIX A

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT

No. 92-3045

OHIO STATE UNIVERSITY, D/B/A OHIO STATE HOSPITALS, PLAINTIFF-APPELLEE

v.

SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

Argued Oct. 13, 1992
Decided June 8, 1993

Before: MARTIN and BOGGS, Circuit Judges; and CONTIE, Senior Circuit Judge.

BOYCE F. MARTIN, JR., Circuit Judge.

The Ohio State University operates a 905-bed acute-care teaching hospital in Columbus, Ohio in conjunction with its medical school. The hospital, administered by Ohio State's medical school, trains recently graduated doctors, called interns and residents, by having them provide patient care. When Medicare was instituted, the federal government began reimbursing the hospital for medical care provided to patients by these doctors. In 1985, the hospital claimed reimbursement from Medicare in the amount of

$765,000 for indirect costs only, which were the overhead costs of its graduate medical program for the provision of patient services. Included in that total was the cost of space, salaries, utilities, supplies, etc. which were related to patient services.

A Medicare intermediary, an entity hired by the Department of Health and Human Services to review cost-reimbursement applications, rejected the hospital's request for reimbursement of indirect costs. Another entity, the Provider Reimbursement Review Board, reversed this decision. Another review followed, and the Deputy Administrator of the Health Care Financing Administration of the Department of Health and Human Services reversed the Review Board's decision, agreeing with the intermediary. Review of the Deputy Administrator's denial of reimbursement was made to the federal district court. The district court granted summary judgment for the hospital, concluding that it was entitled to reimbursement of its costs related to patient care under Medicare. 777 F.Supp. 582. We agree with the district court and affirm.

A resolution of the question before us turns on the interpretation of 42 C.F.R. § 413.85. We are thus again sent into the sea of murky precedents to divine our power to overturn an agency's interpretation of its own regulations.[1] As we read *Whiteside v. Secre-*

[1] Quite frankly, the degree to which courts are bound by agency interpretations of law has been like quicksand. The standard has been constantly shifting, steadily sinking, and, from the perspective of the intermediate appellate courts, frustrating. At first, agency interpretations of law were to be reviewed *de novo*. *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 164, 89 L.Ed. 124 (1944) ("... interpretations and opinions of the Administrator ... while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment...") However, we have

tary of Health & Human Svcs., 834 F.2d 1289, 1292 (6th Cir. 1987), we are bound by an agency's interpretation of its own regulations unless its interpretation is not "reasonable, consistent, and persuasive." In this case, the Secretary's interpretation of 42 C.F.R. § 413.85 is neither reasonable nor persuasive.

As we read the statute, 42 U.S.C. § 1395hh, the Medicare program is designed to reimburse certain

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been told to give "some deference" to the interpretation of the agency. *FTC v. Indiana Fed. of Dentists*, 476 U.S. 447, 454, 106 S.Ct. 2009, __, 90 L.Ed.2d 445 (1986) ("The legal issues presented . . . are . . . for the courts to resolve, although even in considering such issues the courts are to give some deference to the [agency's interpretation]."). And we have been told that we are not to follow an agency's interpretation if the agency's interpretation violates the specific language of the law. *Demarest v. Manspeaker*, 498 U.S. 184, 111 S.Ct. 599, 112 L.Ed.2d 608 (1991) ("But administrative interpretation of a statute contrary to language as plain as we find here is not entitled to deference."). Finally, we have been told that we are not to overturn an agency's interpretation of law if the agency's interpretation is "reasonable." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., et al.*, 467 U.S. 837, 845, 104 S.Ct. 2778, 2783, 81 L.Ed.2d 694 (1984) (Intermediate court is to determine whether agency's view "is a reasonable one."); *Whiteside v. Secretary of Health & Human Svcs.*, 834 F.2d 1289, 1292 (6th Cir. 1987) (The question for the court is "whether the Secretary's interpretation is reasonable, consistent, and persuasive.")

As we noted in *Whiteside*, 834 F.2d at 1292, an agency's interpretation of the law binds this court when the interpretation is "reasonable, consistent, and persuasive." Of course, no court has stated how to determine which interpretations of a statute are "reasonable, consistent, and persuasive" and which are not. So, after all these years of debate and after much judicial ink has been spilled, we are back to essentially the old rule that courts are not bound by agency interpretations of law and that courts are to apply laws based on the court's interpretation of the laws' reasonable meaning. This entire process, travelling far without going anywhere, could have been avoided if the executive branch were left to enforce the law and the judicial branch were left to interpret the law.

reasonable and necessary medical expenses. Educational activities, according to 42 C.F.R. § 413.85, are reimbursable, as reasonable and necessary medical expenses if they are: 1) approved programs; 2) contribute to the quality of patient care within a hospital which receives Medicare; and 3) do not redistribute costs from educational institutions to patient care institutions. This issue was resolved precisely in *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1210 (6th Cir. 1989). In the present case, as in the *University of Cincinnati* case, the graduate medical program was accredited and contributed to patient care in the university-run hospital. The Deputy Administrator in this case, however, determined that the Hospital's request for reimbursement for certain overhead expenses constituted an unlawful redistribution of costs from the graduate program to the hospital.

In our opinion, the Deputy Administrator's decision was based on an unreasonable and unpersuasive interpretation of 42 C.F.R. § 413.85(c). That regulation provides,

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The request for reimbursement for indirect costs, known as overhead expenses outside of government, of its graduate medical program does not constitute a redistribution of costs from the medical program to the hospital. The Department interprets the "redis-

tribution" clause of 42 C.F.R. § 413.85 to mean that costs for patient care, at one time paid by educational institutions but subsequently paid by hospitals, are not reimbursable. The Department's interpretation is neither reasonable nor persuasive because it does not comport with the language of 42 C.F.R. § 413.85(c). The language "educational activities customarily or traditionally carried on by providers in conjunction with their operations" indicates redistribution of kinds of costs, not a temporal redistribution of educational costs. The redistribution clause, therefore, applies to a redistribution of costs from an educational program, such as classroom expenses, to a provider of Medicare medical services. The graduate medical program here does not involve classroom-type expenses, but involves expenses of doctors who are furthering their training by providing medical services. As the district court noted, in finding for Ohio State University,

> [T]he plain meaning of [42 C.F.R. § 413.85(c)] is to authorize reimbursement of all direct and indirect costs related to the kinds of educational activities customarily or traditionally carried on by providers, but to deny reimbursement for costs related to educational activities which are customarily or traditionally carried on by educational institutions, such as medical and nursing schools. The court concludes that the underlying purpose of the redistribution principle is to limit reimbursement to educational costs related to patient care and to deny reimbursement for educational costs unrelated to patient care.

Contrary to the Secretary's interpretation, the dis-

trict court's interpretation of 42 C.F.R. § 413.85(c) is certainly reasonable and persuasive.

The costs claimed by the hospital are not a redistribution of educational costs unrelated to patient care. They are a cost of providing patient care and are reimbursable under 42 U.S.C. § 1395hh and 42 C.F.R. § 413.85(g), which allow recovery of costs of providers of medical services relating to patient care.

The judgment of the district court is affirmed.

BOGGS, J., concurs in the result only.

APPENDIX B

UNITED STATES DISTRICT COURT
S.D. OHIO, E.D.

No. C2-90-905

OHIO STATE UNIVERSITY, D/B/A OHIO STATE UNIVERSITY HOSPITALS, PLAINTIFF

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT

Nov. 13, 1991

MEMORANDUM OPINION AND ORDER

GRAHAM, District Judge.

This is an appeal from a decision of the Administrator of the Health Care Financing Administration ("Administrator") acting on behalf of the Secretary of Health and Human Services ("Secretary") denying plaintiff's claim for provider cost reimbursement under the Medicare Program, 42 U.S.C. § 1395 *et seq.*

Plaintiff The Ohio State University, d/b/a Ohio State University Hospitals (the "Provider") is a state-owned, 905-bed acute care teaching hospital located in Columbus, Ohio. The Provider is a separate administrative division of the University and operates a Medicare-approved graduate medical education

program ("GME program") for interns and residents. The University's College of Medicine ("COM") administers the GME program.

While the Medicare Act itself does not specifically address reimbursement for medical education costs, its legislative history indicates that Congress recognized that many hospitals engage in educational activities which enhance the quality of patient care and that the cost of such activities should be considered an element in the cost of patient care to be borne to an appropriate extent by the Medicare Program. S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. & Ad.News 1943, 1977. The Secretary has adopted regulations authorizing the reimbursement of certain medical education costs. 42 C.F.R. § 413.85.

In administering the Medicare Program the Secretary contracts with fiscal agents known as intermediaries. 42 U.S.C. § 1395h. Intermediaries review cost reports submitted by providers at the end of each fiscal year in order to make a final determination of the reimbursable costs which may be allowed to the providers. 42 U.S.C. § 1395g; 42 C.F.R. §§ 413.20(b), 413.24(f), 413.60.

Since the inception of the Medicare Program, the Provider has claimed and received reimbursement for certain direct costs relating to the GME program. In 1985 the Provider employed a Medicare reimbursement expert to review its cost reports to insure that it was recouping all costs permitted by law. As a result of this individual's advice, the Provider included indirect costs, variously referred to as overhead or general and administrative (G & A) costs related to the GME program for fiscal year 1985. The

intermediary disallowed these costs, resulting in a reduction in the Provider's Medicare reimbursement in the approximate amount of $765,000. The Provider requested a hearing before the Provider Reimbursement Review Board ("PRRB"). The PRRB is a panel of five individuals appointed by the Secretary whose responsibilities include the mediation of disputes between providers and intermediaries. The members of the PRRB are required by statute to be knowledgeable in the field of medicare cost reimbursement and at least one of them must be a certified public accountant. 42 U.S.C. § 1395*oo* (h). On August 17, 1990 the PRRB reversed the intermediary, holding that:

> The amounts of graduate medical education and physician administrative costs claimed by the Provider are allowable related-party costs subject to audit by the intermediary.

PRRB decision, p. 18. The Administrator then notified the parties of his intention to review the PRRB's decision, and on October 16, 1990, the Administrator reversed the PRRB, holding that the claimed costs were not allowable graduate medical education costs. The Provider appealed the Administrator's decision to this Court and the case is now before the Court on the parties' cross motions for summary judgment.

The Administrator denied the Provider's claim for overhead and administrative expenses related to its GME program on two grounds: first, that reimbursement would violate the Secretary's regulation against redistribution of the costs of an educational institution, 42 C.F.R. § 413.85(c), and second, that the overhead and administrative costs are not allowable costs

for Medicare purposes under Medicare law and regulations.

STANDARD OF REVIEW

Judicial review of the Administrator's decision is governed by 42 U.S.C. § 1395*oo*(f) which incorporates the judicial review provisions of the Administrative Procedure Act, 5 U.S.C. § 706. This standard requires a court to set aside agency action "which is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law; contrary to a Constitutional right, power, privilege or immunity; or unsupported by substantial evidence where an agency hearing is being reviewed on the record." *Bedford County General Hospital v. Heckler,* 757 F.2d 87, 89 (6th Cir. 1985). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales,* 402 U.S. 389, 401, 91 S.Ct. 1420, 1427, 28 L.Ed.2d 842 (1971).

An administrative agency's interpretation of its own regulations is accorded considerable deference unless it is inconsistent with the plain language of the regulations. *University of Cincinnati v. Heckler,* 733 F.2d 1171, 1173-74 (6th Cir. 1984); *University of Cincinnati v. Bowen,* 875 F.2d 1207, 1208 (6th Cir. 1989). Although an agency's decision is entitled to a presumption of regularity, a reviewing court is required to engage in a thorough, probing, in-depth review. *Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 415, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971).

THE ISSUE OF DISTRIBUTION

Medicare regulations specifically authorize the reimbursement of the cost of certain educational activities. The following principles govern the reimbursement of such costs:

1. The education program must be approved.
2. The program must contribute to the quality of patient care within an institution.
3. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities.
4. It is not intended that the program should participate in increased costs resulting from redistribution of costs from educational institutions to patient care institutions.

42 C.F.R. § 413.85(c). *University of Cincinnati v. Bowen*, 875 F.2d at 1210; *St. John's Hickey Memorial Hospital, Inc. v. Califano*, 599 F.2d 803, 809-810 (7th Cir. 1979). It is uncontroverted that the Provider's GME program is approved and does contribute to the quality of patient care within the hospital.

The intermediary based its disallowance of the Provider's GME overhead costs in part on a finding that reimbursement would violate both the community support and redistribution principles set forth in 42 C.F.R. § 413.85(c). The PRRB disagreed, finding that reimbursement would violate neither principle. In reversing the PRRB and finally denying reimbursement, the Administrator relied only on the principle of redistribution. In this respect, the Administrator's decision differs from his decisions in *Thomas Jefferson University Hospital v. Aetna Life Insurance Co.*, CCH Medicare & Medicaid Guide, § 38,353 (Jan.

18, 1990) and *University of Minnesota Hospitals v. Blue Cross & Blue Shield Assoc.*, CCH Medicare and Medicaid Guide § 39,420 (May 29, 1991), in which he invoked the community support principle of the rule and found that reimbursement of G & A costs should be disallowed because they had historically been borne by the community. This also distinguishes the present case from *Board of Trustees of State Institutions of Higher Learning v. Sullivan*, 763 F.Supp. 178 (S.D. Miss. 1991).

The Court concludes that the Secretary did not rely on the community support principle because the evidence in this case would not support a finding that the community had undertaken to bear the overhead expenses of the Provider's GME program. The record here discloses that the Provider has historically transferred substantial funds to the COM in general support of its services to the GME program (seven million dollars in fiscal year 1985) and that from fiscal year 1983 through fiscal year 1988, the Provider incurred operating losses of approximately fifteen million dollars. In any event, since the Secretary did not rely on the principle of community support, that issue is not before the Court. An agency's decision must be upheld, if at all, on the same basis articulated by the agency itself. *Federal Power Commission v. Texaco, Inc.*, 417 U.S. 380, 397, 94 S.Ct. 2315, 2326, 41 L.Ed.2d 141 (1974).

The redistribution principle of the rule is stated in the following language:

> . . . Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not

> intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

42 C.F.R. § 413.85(c). A threshold question in interpreting the rule is the meaning of "costs" in the context of Medicare reimbursement regulations. Are they limited to expenses actually incurred and paid by the provider? Are they limited to direct costs? Clearly, the answer to both of these questions is no.

The provisions of 42 C.F.R. § 413.17(a) expressly authorize reimbursement of costs applicable to services, facilities and supplies furnished to a provider by organizations related to the provider by common ownership or control:

> (a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

The College of Medicine and the hospital are both owned by the University. The Secretary has recognized the College of Medicine as a related organization within the purview of 42 C.F.R. § 413.17 and has always approved reimbursement for the direct costs of the GME program provided by the College of Medicine.

The provisions of 42 C.F.R. § 413.85(g) expressly authorize reimbursement of both direct and indirect costs of approved educational activities:

> *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and *other direct and indirect costs of the activities* as determined under the Medicare cost-finding principles in § 413.24. (Emphasis added).

Indirect costs include overhead. *University of Cincinnati v. Bowen*, 875 F.2d at 1208. "The costs of approved educational activities, such as stipends paid to residents and related overhead, are ordinarily included as reasonable costs." *Id.*

The Administrator's finding that the allowance of the Provider's GME overhead and administrative costs would violate the redistribution principle of 42 C.F.R. § 413.85(c) is based primarily on the fact that these costs had not previously been claimed by the Provider as GME costs. The Administrator noted at page 4 of his decision, "The overhead costs of the medical school claimed here had not previously been claimed by the Provider as GME costs."

The Administrator went on to state, at page 5 of the decision:

> The Provider maintains that, although it has not claimed these costs in prior years, there is no redistribution of the cost of the medical school to the Provider. . . . , the Provider states that it has always paid these costs. Although the Provider

> has alleged that it has always paid these costs, it also stated that these costs have been absorbed by the Provider *and* the college. There is, however, no evidence, in the record identifying these costs as having been incurred or reported by the Provider in prior years.
>
> Therefore, although the Provider alleges that there is no redistribution of costs, there is no evidence in the record to support the Provider's allegation. This information is within the purview of the Provider. The record does not support the allegation that the Provider incurred these costs in prior years. If these costs were paid as the Provider alleges, the record does not explain how these costs were treated on the Provider's cost report for those years or what effect this had on Medicare reimbursement.

Aside from quoting the redistribution provisions of the regulation, the above constitutes the totality of the grounds given by the Administrator for disallowing these costs under 42 C.F.R. § 413.85(c).

It is clear from the Administrator's reasoning that his denial of reimbursement was based on an interpretation of the rule which requires a provider to show that it has historically incurred, paid and reported GME costs in order to avoid the redistribution prohibition. The Administrator seems to have applied the "customary and traditional" test to paying and claiming the cost of the educational activities instead of the performance of the educational activities. The Court finds that such an interpretation is not consistent with the plain language of the regulation and conflicts with the provisions of other regulations and the Medicare statute itself.

The prohibition against redistribution is embedded in a clause which begins with a declaration of the program's intent to share in the support of educational activities "customarily or traditionally carried on by providers in conjunction with their operations." 42 C.F.R. § 413.85(c). It is the activities which must be customary and traditional, not the provider's practice of paying for them or claiming reimbursement for them. Redistribution is not defined, but in context it is linked both to the customary and traditional educational activities of providers and to a declaration of the program's intent not to participate in "increased costs resulting from the redistribution of costs from educational institutions or units to patient care institutions or units." *Id.* The regulation's reference to both educational institutions and educational units indicates that the redistribution principle focuses on activities as opposed to entities.

The regulation expresses the intent of the Medicare program to share in the support of educational activities carried on by providers. This is consistent with the legislative history of the statute which reflects Congress's intent that the Medicare program pay its fair share of educational activities which contribute to the quality of patient care. S.Rep. No. 404, *supra*. The regulation further reflects an intent to limit such support to the kinds of educational activities customarily or traditionally carried on by providers in conjunction with their operations. It is not entirely clear whether this refers to the kinds of educational activities customarily or traditionally carried on by providers in general or by a specific provider. It seems more likely that the former is intended, but in this case it is not necessary to decide

that point since the educational activities here in question are of the kind customarily and traditionally carried on by teaching hospitals in general and by this Provider in particular. The record shows that the Provider has historically operated its GME program using the services of the College of Medicine. Thus, it is clear that this educational activity is one which has customarily and traditionally been carried on by this Provider in conjunction with its operations.

Teaching hospitals traditionally and customarily engage in the clinical training of graduate physicians in the hospital setting. Ordinarily they do not engage in classroom training, undergraduate medical education or other nonclinical educational activities. These nonclinical medical educational activities are customarily and traditionally carried on by educational institutions. Hospitals often engage in educational activities with respect to other health care occupations. A list of recognized professional and paramedical educational training programs is found in 42 C.F.R. § 513.85(e), and it includes such programs as professional nursing, practical nursing, occupational therapy, pharmacy, physical therapy, and x-ray technology. The customary or traditional role of a hospital in such educational programs would undoubtedly vary, depending on the kind of training involved.

In the case of graduate medical education, it would be customary and traditional for a teaching hospital to employ qualified physicians in various medical specialties to select and supervise the interns and residents enrolled in the educational program. These physicians would need clerical and administrative staff, office space and supplies to carry out their

function. Their salaries, the salaries of their clerical and administrative staffs, and the cost of their office space and supplies would all be part of the cost of the educational activity which ultimately contributes to the quality of patient care in the hospital. Such costs would be the traditional and customary costs incurred by a teaching hospital engaged in a graduate medical education program. They would be the kind of costs Congress intended that the Medicare program should participate in. If the Medicare program did not pay its fair share of these costs, there is a likelihood that they would be shifted to non-Medicare patients in violation of the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A), which prohibits the shifting of the necessary direct and indirect costs of delivering health care services from Medicare to non-Medicare beneficiaries.

Thus, the Court concludes that the plain meaning of 42 C.F.R. § 413.85(c) is to allow providers to receive reimbursement for a fair share of all direct and indirect costs related to educational activities customarily or traditionally carried on by providers in conjunction with their operations.

The prohibition against redistribution of costs from educational institutions or units to patient care institutions or units seems to be intended to guard against a situation in which a provider would undertake educational activities beyond those which are customary and traditional and ask the Medicare program to participate in such increased costs. For instance, a hospital might expand its educational activities to include nonclinical educational activities, such as undergraduate instruction or other activities customarily and traditionally carried on by educa-

tional institutions but not customarily and traditionally carried on by patient care institutions. These would be increased costs which the Medicaid program will not participate in.

Thus, the Court concludes that the plain meaning of the regulation is to authorize reimbursement of all direct and indirect costs related to the kinds of educational activities customarily or traditionally carried on by providers, but to deny reimbursement for costs related to educational activities which are customarily or traditionally carried on by educational institutions, such as medical and nursing schools. The Court concludes that the underlying purpose of the redistribution principle is to limit reimbursement to educational costs related to patient care and to deny reimbursement for educational costs unrelated to patient care.

In order to find that the allowance of GME administrative and overhead costs would violate the rule against redistribution of claimed costs from educational institutions or units to patient care institutions or units, there would have to be evidence that the costs included purely educational costs unrelated to patient care, such as the cost of undergraduate medical education programs or nonclinical graduate medical education programs. There is no evidence that this occurred in the present case.

The Administrator seems to have concluded that since these costs had not been claimed in prior years, there was an irrebuttable presumption that they represented a redistribution of the costs of the medical school to the Provider. Where a provider gives a legitimate explanation for its failure to report or claim the costs in prior years, a refusal to consider

the allowability of the costs is arbitrary and capricious.

The regulations do not prohibit all shifting of costs from educational institutions or units to patient care institutions or units. Only improper cost shifting is prohibited. So long as the educational activities enhance the quality of Medicare patient care in the hospital, such costs

> are *properly* shifted to the patient care institution and its Medicare beneficiaries. This comports with the underlying statute, 42 U.S.C. § 1395x(v)(1)(A), which prohibits shifting necessary direct or indirect costs of providing services from Medicare beneficiaries to non-Medicare beneficiaries. Therefore, by allocating a proper amount of the clinical costs to the Medicare Program, it has not "participate[d] in increased costs resulting from redistribution of costs from educational institutions to patient care institutions." 42 C.F.R. § 405.421(c) (1982). The Hospital seeks only reimbursement for the *allocable* share of costs, *i.e.*, the costs equal to the proportion of Medicare patients at the Hospital relative to the Hospital population. *See* 42 C.F.R. § 405.402(a) (1982). (emphasis in the original).

University of Cincinnati v. Bowen, 875 F.2d at 1212.

THE ISSUE OF ALLOWABILITY

The Administrator found that even if the overhead costs of the GME program did not violate the redistribution principle of 42 C.F.R. § 413.85(c), the costs would still not be allowable GME costs because they are the overhead costs of the medical school instead

of the hospital and because they are not related to the care of beneficiaries.

The Administrator acknowledges that 42 C.F.R. § 413.85(a)(1) provides for reimbursement of the net costs of approved educational activities and that the net costs of those activities are to be determined in accordance with 42 C.F.R. 4513.85(g) which states that a provider's total costs "include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24." The Administrator concludes, however, that indirect costs in this context refers "to the administrative and general cost of the hospital, not the medical school." Administrator's Decision, p. 7. This interpretation conflicts with the plain language of § 413.85(g) when read in light of the related party rule, 42 C.F.R. § 413.17. Clearly, both direct and indirect costs of approved educational activities are reimbursable under § 413.85(g). It makes no sense to say that direct costs are reimbursable if incurred by a provider or a related medical school but that indirect costs are reimbursable only if incurred by the provider. This contradicts the provisions of 42 C.F.R. § 413.17 and the statutory mandate that the Medicare program pay its fair share of patient costs and ignores the evidence that during the year in question the Provider transferred $7 million to the medical school in support of the GME program.

Indirect costs are a necessary part of the cost of educational programs which contribute to the quality of patient care. Under the Administrator's interpretation, a "stand alone" teaching hospital would be entitled to recover the overhead costs of its GME

program but a teaching hospital which relies on the services of a medical school would not. Such an interpretation is arbitrary and unreasonable and contrary to the law as announced in *University of Cincinnati v. Bowen*, 875 F.2d at 1208, where, as noted previously, the court held that overhead costs of a GME program operated by a related medical school are ordinarily included as reasonable costs.

The Administrator asserts that his interpretation is consistent with longstanding Medicare policy stated in Intermediary Letter No. 78-7 issued in February, 1978. However, this Intermediary Letter clearly authorizes reimbursement for indirect costs of a related medical school of the very kind here in controversy. The intermediary letter begins as follows:

> PROVIDER REIMBURSEMENT—COST TO RELATED ORGANIZATIONS—MEDICAL SCHOOL FACULTY COSTS—.
>
> New instructions in this *Intermediary Letter* recognize as allowable hospital costs: (1) reasonable costs incurred by a teaching hospital for patient care services rendered by the faculty of a related medical school in the hospital and (2) reasonable costs incurred in the medical school that are related to the rendition of those services. Allowable faculty costs include direct salaries, applicable fringe benefits, FICA, and unemployment taxes and workmen's compensation and may include travel and sabbatical leave costs, membership fees, and book allowances when directly applicable to services rendered by the medical school faculty. Allowable faculty-related costs incurred in the medical school are generally lim-

> ited to "direct" costs and "space" costs associated with a medical library, physician office space and clerical support where the hospital does not have its own medical library or administrative structure and does not provide office space or clerical support to the medical school faculty.

Brief of Plaintiff, Ex. J. Physician office space and clerical support are two of the specific items claimed by the Provider and they are clearly examples of indirect or overhead costs which, under this Intermediary Letter, are properly reimbursable costs of a related medical school. Thus, Intermediary Letter No. 78-7 does not support the Administrator's interpretation of the regulation but in fact supports the Provider's interpretation of that regulation.

The Administrator's position here is also contrary to the position taken in a Health Care Financing Administration (HCFA) Commentary dated September 29, 1989. In response to a comment about treatment of GME costs of a related medical school in which the commenter pointed out that in some instances GME activities may take place in space assigned to the medical school, HCFA responded in part as follows:

> Certain identifiable activities conducted by the faculty of a related medical school, which are necesssary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes. . . .
>
> These items and services must be necessary and directly related to the provision of medical school faculty services in the hospital and may not be duplicative of items and services furnished

> by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs that are incurred by the university medical school may be allowable . . . 54 Fed.Reg. 40,302 (Sept. 29, 1989).

Brief of plaintiff, Volume II—Appendix N.

There is no evidence that the Provider itself has the ability to provide the necessary administrative structure, space and clerical staff needed to support the GME program without using the resources of the COM. The Administrator's interpretation of the regulations denying reimbursement on the ground that the GME overhead costs are the costs of the COM and not the Provider is contrary to the plain wording of the regulations and the Secretary's previous interpretations of those regulations.

The Administrator also denied reimbursement on the grounds that the Provider's GME overhead costs were not "related to the care of beneficiaries" and were not "incurred for patient care services" (Administrator's decision, pp. 7, 8). The Sixth Circuit rejected such a limited interpretation of the Medicare regulations in *University of Cincinnati v. Bowen*, 875 F.2d at 1211, when it held, "The Secretary's argument fails for the simple reason that section 405.421(c) [now § 413.85(c)] only requires educational 'activities' that ultimately enhance the quality of Medicare patient care, not direct 'services' to those patients."

The Administrator states, "Medicare will not reimburse costs of the medical school which are duplicative of costs of the hospital and which are not related to the patient care furnished in the hospital." Administrator's Decision, p. 9. There is no evidence

in the record that the overhead costs in question are duplicative of costs of the hospital, nor is there any evidence that the costs are not related to the patient care furnished in the hospital. Indeed, the evidence indicates that they are related to the patient care furnished in the hospital because the residents and interns and the physician faculty members supervising them could not function without office space, professional and clerical staff and supplies.

The record shows that in calculating the overhead costs of the GME program, the Provider adopted a methodology which excluded all educational costs which were not related to patient care. All undergraduate educational expenses were excluded. Costs related to the five nonclinical departments were excluded. The GME overhead costs represent the allocated administrative costs of each COM clinical department. They include the salaries and fringe benefits of professional nonphysician working staff, including office managers and programmers who support the faculty members, clerical personnel and secretaries working for them and their professional staffs, space costs consisting of depreciation, utilities and related costs of the offices they occupy and the costs of supplies they consume. Any teaching hospital would necessarily incur such overhead and administrative costs simply because the physicians operating such programs could not function without support staff, clerical employees, office space and supplies.

CONCLUSION

Plaintiff's motion for summary judgment is well taken. The Clerk shall enter judgment in favor of the plaintiff reversing the Administrator's decision of

October 15, 1990 and remanding this case to the Secretary of the United States Department of Health & Human Services with instructions to allow plaintiff's claim for GME overhead costs for the 1985 cost-reporting year in the amount of $765,000.00 with interest pursuant to 42 U.S.C. § 1395*oo* (f)(2).

It is so ORDERED.

APPENDIX C

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT

No. 92-3045

OHIO STATE UNIVERSITY, D/B/A OHIO STATE UNIVERSITY HOSPITALS, PLAINTIFF-APPELLEE

v.

SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

[Filed Aug. 4, 1993]

Before: MARTIN and BOGGS, Circuit Judges; and CONTIE, Senior Circuit Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original sub-

mission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green
Leonard Green, Clerk

APPENDIX D

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. Section 1395x(v)(1)(A)

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipient of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred

costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 C.F.R. § 413.85. Cost of educational activities.

(a) *Payment*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to appor-

tionment based on Medicare utilization as described in § 413.50.

* * * * *

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

* * * * *

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

42 C.F.R. § 413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

* * * * *

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No. 93-696

In The

Supreme Court of the United States

October Term, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

OHIO STATE UNIVERSITY D/B/A OHIO STATE UNIVERSITY HOSPITALS,

Respondent.

On Petition For A Writ Of Certiorari To the Sixth Circuit Court of Appeals

BRIEF FOR THE RESPONDENT IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Petitioner has presented the following question:

> Under Medicare regulations, the cost of training programs for interns and residents (known as graduate medical education, or GME, programs) is an "allowable cost" for which a hospital may receive reimbursement. 42 C.F.R. 413.85(a). Reimbursement is not available, however, for any "increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

The issue presented is:

> Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars a hospital providing Medicare services from obtaining reimbursement of otherwise reimbursable GME program costs that previously were absorbed by its affiliated medical school.

As is discussed in this brief in opposition, neither an affirmative nor a negative response to the question presented by Petitioner would alter the outcome of this case. Rather, in order for this case to be affected by Petitioner's issue in *Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Shalala*, petition for certiorari pending No. 93-120, it would be necessary for this Court to reverse the factual determinations of the lower court.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF AUTHORITIES iii

JURISDICTION 1

STATEMENT OF THE CASE 1

REASONS FOR DENYING THE PETITION 3

The Facts of This Case are Distinguishable From the Facts in the Case of Thomas Jefferson 4

Petitioner's Request That This Case be "Held" is Inappropriate and Would Be Unfair to Respondent 7

CONCLUSION 8

TABLE OF AUTHORITIES

Page

CASES

Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Shalala, petition for certiorari pending, No. 93-120 ..... 2, 4, 5, 6, 7, 8, 9

University of Minnesota v. Shalala, CCH Medicare & Medicaid Guide, Para. 41,726 at p. 37,531 6

Ohio State University v. Sullivan, 777 F. Supp. 582 (S.D. Ohio 1991) 2, 5, 6

STATUTES AND REGULATIONS

28 U.S.C. 1254(1) 1

No. 93-696

In The

Supreme Court of the United States

October Term, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

OHIO STATE UNIVERSITY D/B/A OHIO STATE UNIVERSITY HOSPITALS,

Respondent.

On Petition For A Writ Of Certiorari To the Sixth Circuit Court of Appeals

BRIEF FOR THE RESPONDENT IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

JURISDICTION

Respondent does not take issue with the Petitioner invoking the jurisdiction of this Court under 28 U.S.C. 1254(1).

STATEMENT OF THE CASE

Respondent does not take issue with Petitioner's historical review of the Medicare program except to disagree with Petitioner's statement that Congress' decision to

make fiscal year October 1, 1983 through September 30, 1984 the base year for subsequent reimbursement of graduate medical education ("GME") costs was part of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 331. This is incorrect. Rather, this decision was part of the Consolidated Omnibus Reconciliation Act of 1985 passed by Congress in April of 1986, Pub. L. No. 99-272, § 9202.

Respondent does take issue with Petitioner's review of the facts. Petitioner has represented that the facts of this case are the same as those before this Court in the case of *Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Shalala*, petition for certiorari pending, No. 93-120. This is incorrect. In the present case both the Provider Reimbursement Review Board ("PRRB") and the District Court for the Southern District of Ohio found that there had been no prior community support for the GME costs at issue in this case. Rather, Respondent had always been responsible for these costs. The Sixth Circuit Court of Appeals affirmed.

The evidence presented in this case established that Respondent had historically transferred substantial funds to the college of medicine in general suppport of its services to the GME program (seven million dollars in fiscal year 1985) and that from fiscal year 1983 through fiscal year 1988, Respondent incurred losses of approximately fifteen million dollars in operating its GME program. No evidence was presented which would support a finding that the community had undertaken to bear the overhead expenses of Respondent's GME program. *Ohio*

State University v. Sullivan, 777 F. Supp. 582, 585 (S.D. Ohio 1991), at Petitioner's App. 12a.[1]

Based upon these undisputed facts, the district court held that the Secretary had not relied upon the community support principle "because the evidence in this case would not support a finding that the community had undertaken to bear the overhead expenses of the Provider's GME program." *Id.* Rather, the court found that the Secretary had relied solely upon the redistribution principle. Therefore, the court's role was to determine whether the overhead costs **which had been borne by Respondent in the past** qualified as allowable costs. *Id.* at 588; Petitioner's App. 19a-20a. The court held that they did and therefore reversed the Secretary's decision to the contrary. The Secretary has specifically not raised the issue of allowable costs in this petition. *See*, Brief for Petitioner on Petition for Writ of Certiorari at p. 6, n. 5.

REASONS FOR DENYING THE PETITION

Respondent Ohio State University d/b/a Ohio State University Hospitals respectfully requests that this Court deny the petition for writ of certiorari seeking review of

[1] At footnote 7 of its petition, Petitioner states that "most GME-related costs . . . were absorbed directly by the medical school." There is absolutely no authority for this statement other than reliance upon a phrase from Respondent's post-hearing brief in which the related entities' principle was being argued. The Petitioner's statement also stands in direct contradiction to the district court's decision.

the decision of the United States Court of Appeals for the Sixth Circuit in this case.

Alternatively, in the event this Court determines that it will exercise its jurisdiction, Respondent urges this Court to deny Petitioner's request that this case be stayed pending this Court's decision in *Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Shalala*, petition for certiorari pending, No. 93-120. Rather, the cases should be consolidated in order that Respondent has the opportunity to address the arguments which have been presented and to distinguish the facts of its case prior to this Court rendering its decisions.

The Facts of This Case Are Distinguishable From the Facts in the Case of Thomas Jefferson

The sole reason asserted by Petitioner as a basis upon which this Court should exercise its jurisdiction is that the question presented in both cases is the same:

> The question presented in both cases is whether the Secretary of Health and Human Services reasonably interpreted the regulation as barring reimbursement to a hospital of GME-related costs that in previous years had been absorbed by the hospital's affiliated medical school, but are now being claimed by the hospital for reimbursement under Medicare.

Petitioner's Petition at p. 7. If such costs have been absorbed by the affiliated medical school, the Secretary has taken the position that this constitutes past community support and, therefore, the claimed costs are not reimbursable. If there has been no community support,

however, then the Secretary has recognized that such costs are reimbursable.

In the present case, the district court, whose decision was affirmed by the appellate court, specifically held that the GME costs had NOT been previously absorbed by the medical school. Rather, the costs had been borne by Respondent. Accordingly, the key issue in *Thomas Jefferson* – community support – is not at issue here. It would therefore be necessary for this Court to reverse the factual determinations of the lower court in order for this case to present the same issue as that before this Court in *Thomas Jefferson*.

As was stated by the district court:

> In reversing the PRRB and finally denying reimbursement, the Administrator relied only on the principle of redistribution. In this respect, the Administrator's decision differs from his decisions in *Thomas Jefferson University Hospital v. Aetna Life Insurance Co.*, CCH Medicare & Medicaid Guide, § 38,353 (Jan. 18, 1990) and *University of Minnesota Hospitals v. Blue Cross & Blue Shield Assoc.*, CCH Medicare and Medicaid Guide § 39,420 (May 29, 1991), in which he invoked the community support principle of the rule and found that reimbursement of G & A costs should be disallowed because they had historically been borne by the community. This also distinguishes the present case from *Board of Trustees of State Institutions of Higher Learning v. Sullivan*, 763 F. Supp. 178 (S.D. Miss. 1991).

Ohio State University, 777 F. Supp. at 584-85, at Petitioner's App. 11a-12a.

This factual difference is also reflected in the district court's opinion in *Thomas Jefferson*, CCH Medicare & Medicaid Guide, Para. 40,294 at p. 30,963:

> In concluding that the Hospital was not entitled to the level of reimbursement claimed in connection with its GME program, the Administrator determined that the Hospital had run afoul of both the community support and the redistribution criteria. . . .

The court then reviewed the Secretary's decision which had found that community support included "tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware." *Id.* at 30,965.[2]

In *University of Minnesota v. Shalala*, CCH Medicare & Medicaid Guide, Para. 41,726 at p. 37,531, the District Court for the District of Minnesota also recognized that the facts before it and before the court in *Thomas Jefferson* were different than those at issue in this case:

> Unlike in *Ohio State University v. Sullivan*, 777 F. Supp. 582, 588 (S.D. Ohio 1991), where the provider incurred an operating loss for the years in question, here there is no evidence that the provider operated at a loss or that the costs at issue were not in fact absorbed by the Medical School from its various funding sources. The Secretary's decision that the costs at issue were borne

---

[2] Reference to the Secretary's determination of what constitutes community support should not be construed as agreement with the Secretary's position. Respondent does not take issue with the position simply because it is irrelevant to the specific facts of Respondent's case.

> by the community was based on the substantial evidence.

Id. at 37,536.

Accordingly, there is no "square circuit conflict" as claimed by Petitioner in that the decision in this case does not stand for the proposition that a provider may claim reimbursement regardless of whether the costs had previously been claimed or paid by the provider as is alleged by the Petitioner. Rather, the decision in this case permitted recovery of allowable costs which had been previously incurred by the provider.

Petitioner's Request That This Case be "held" is Inappropriate and Would Be Unfair to Respondent

It is only by disregarding or disagreeing with the factual determinations of the lower court that an issue is presented consistent with that before this Court in *Thomas Jefferson*. Accordingly, the question presented by Petitioner does not present a basis upon which this Court should exercise its jurisdiction. However, should the Court exercise its jurisdiction, Respondent would be severely prejudiced if its case were "held" in abeyance pending this Court's decision in *Thomas Jefferson*. The reasons for this are twofold.

First, as has been previously stated, this case is factually different. Petitioner's argument in *Thomas Jefferson* as well as in the present case is that the Secretary recognizes a distinction between cases in which the community has

undertaken to absorb the costs of medical training programs and cases in which the community has not undertaken such responsibility. *See,* Brief for Respondent on Petition for Writ of Certiorari in *Thomas Jefferson,* at pp. 7-8. In the present case, the lower court determined that the only evidence presented established that the community had **not** absorbed the costs of Respondent's program. Rather, the costs had been borne by Respondent. Accordingly, this Court would be better informed if it was fully briefed as to both sets of facts prior to rendering a decision which will affect both cases.

Second, although this case is factually different, Respondent has several legal arguments which it would present in opposition to the arguments being advanced by Petitioner. If this Court exercises its jurisdiction but then holds this case in abeyance, Respondent will have been denied the opportunity to present its arguments to the Court prior to this Court rendering a decision which will substantially affect Respondent's rights. This would occur despite the fact that the case had been pending before the Court at the same time as the *Thomas Jefferson* case.

CONCLUSION

Petitioner has asked this Court to exercise its jurisdiction because Petitioner disagrees with a factual determination of the lower court. The role of this Court is to resolve legal issues of great public import, not to reverse findings of fact in order to be able to reach legal issues. Respondent therefore respectfully requests that this

Court deny the petition for writ of certiorari. Alternatively, Respondent respectfully requests, in the event the petition is granted, that this case be consolidated with *Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Shalala*, petition for certiorari pending, No. 93-120, or that Respondent otherwise be granted the opportunity to fully brief and argue its case prior to a Court decision in the *Thomas Jefferson* case.

Respectfully submitted,

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No. 96-1660

In the Supreme Court of the United States

OCTOBER TERM, 1996

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

STATE UNIVERSITY, d/b/a OHIO STATE HOSPITALS

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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TABLE OF AUTHORITIES

Case:	Page
Thomas Jefferson University Hospital v. *Shalala*, petition for cert. pending, No. 93-120 (filed July 20, 1993)	1, 8

Regulation:

42 C.F.R. Section 413.85(c)	3, 5, 7

In the Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-696

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

OHIO STATE UNIVERSITY, d/b/a OHIO STATE HOSPITALS

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

Respondent does not dispute that the court of appeals' interpretation of the anti-redistribution provision at issue in this case conflicts with that of the Third Circuit that is before this Court in *Thomas Jefferson University Hospital* v. *Shalala*, petition for certiorari pending, No. 93-120 (filed July 20, 1993). See 93-120 Gov't Br. 9-10; 93-696 Pet. 7-8. Nor does respondent dispute that the question presented concerning the reimbursement of graduate medical education (GME) expenses is one of recurring

importance under the Medicare Program that warrants review by this Court. See 93-120 Gov't Br. 10-12. Respondent instead argues that the petition in this case should be denied because the legal issue on which the circuits are divided need not have been reached on the facts of this case. Respondent is wrong regarding the factual posture of the case. And, in any event, the Sixth Circuit did decide the legal issue, and our certiorari petition seeking review of its ruling therefore should be held pending the disposition of the petition and the decision in *Thomas Jefferson* on the same question.

1. In arguing that the Court should not hold this case pending the disposition of *Thomas Jefferson*, respondent presents a distorted picture of the administrative and judicial decisions below. Contrary to respondent's suggestion (Br. in Opp. 5), the district court's decision cannot fairly be read as making a definitive ruling on the factual issue of whether the medical school affiliated with the provider, respondent Ohio State University Hospitals, had ever previously absorbed a portion of the GME-related overhead costs for which the provider was seeking Medicare reimbursement. Moreover, the court of appeals was silent concerning the factual issue of whether the medical school had historically absorbed any of the GME-related overhead costs incurred at the medical school and claimed by the provider for the first time in 1985.

Neither court below had any occasion to identify the previous sources of financial support for the provider's GME programs, because both courts interpreted the final clause of the anti-redistribution

regulation, 42 C.F.R. 413.85(c),[1] as permitting Medicare reimbursement for the costs of all GME-related activities that contribute to the quality of patient care in the year for which reimbursement is sought. See Pet. App. 19a (stating district court's conclusion that the regulation bars reimbursement only of "purely educational costs unrelated to patient care, such as the cost of undergraduate medical education programs or nonclinical graduate medical education programs."); *id.* at 5a (similar conclusion by court of appeals). On this reading of the anti-redistribution regulation, the provider hospital's entitlement to reimbursement for all direct and indirect GME-related costs, including those incurred by an affiliated medical school, would not depend on which entity had previously absorbed or paid those costs, but only on the type of costs that were claimed. Thus, it would not matter whether the costs incurred in connection with the hospital's GME program had previously been paid by the medical school, the provider hospital, or by some other outside source of funding.

In contrast, the Administrator of the Health Care Financing Administration (acting for the Secretary of Health and Human Services) ruled that reimbursement for the GME-related costs claimed by the provider would result in a redistribution of costs from the medical school to the provider, because the provider had failed to show that it had previously absorbed all the costs of GME-related services that

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[1] The pertinent clause of the anti-redistribution regulation states that "it is not intended that [the Medicare] program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

were provided by the medical school. C.A. App. 103.[2] Accordingly, the Administrator concluded that to grant Medicare reimbursement to the provider for "[t]he overhead cost of the medical school" would result in "a redistribution of costs in violation of 42 C.F.R. 413.85." *Ibid.*[3]

2. To be sure, the district court appeared to disparage the Administrator's conclusion that, because the provider had failed to prove that it had previously paid all the GME overhead costs it was now claiming, the medical school must have absorbed these costs in the past. See Pet. App. 14a-15a, 19a-20a. But neither court below overturned the Secretary's factual determination on that issue. Even if the Administrator's conclusion on that factual issue was erroneous, however, this case should still be held pending this

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[2] The Administrator pointed out that "although the Provider has alleged that it has always paid these costs, it also stated that these costs have been absorbed by the provider *and* the college [of medicine]" in previous years. C.A. App. 99. The Administrator further stated that "[t]he record does not support the allegation that the Provider incurred these costs in prior years," pointing out that "[t]his information is within the purview of the provider." See also *id.* at 103 (formal finding of fact that the provider "did not demonstrate that the overhead costs of the medical school were paid by the provider in prior years").

[3] The Administrator also denied reimbursement on the alternative ground that, even apart from the prohibition on redistribution, the claimed "overhead cost[s] of the medical school are not allowable costs for Medicare purposes." C.A. App. 103. That ruling was reversed by the district court and was not challenged by the government on appeal. It is therefore not at issue in this Court.

Court's disposition of the petition in *Thomas Jefferson*.

The question presented in *Thomas Jefferson* is whether the Secretary may apply 42 C.F.R. 413.85(c) to bar a hospital from obtaining Medicare reimbursement of otherwise reimbursable GME program expenses that were found to have been absorbed in previous years by its affiliated medical school. See *Thomas Jefferson* Pet. App. 22a ("It is uncontroverted that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School."); see also *id.* at 19a. The Third Circuit in that case relied on two separate grounds in holding that the provider was not entitled to reimbursement for previously unclaimed GME-related costs. First, it held that the final clause of the anti-redistribution regulation, which forbids the shifting of costs from an educational institution to a patient care institution, barred reimbursement of costs that had previously been paid by petitioner's affiliated medical school. *Thomas Jefferson* Pet. App. 20a-22a. The Third Circuit's holding on that issue is directly contrary to the Sixth Circuit's decision in the instant case. See Pet. App. 4a-6a. The Third Circuit further held in *Thomas Jefferson* that to reimburse the provider for previously unclaimed GME-related costs would violate the broader "community support" principle in the regulation, which the Secretary had interpreted as barring Medicare reimbursement to a provider for educational costs previously paid by the provider out of funds received from sources in the community at large. See 42 C.F.R. 413.85(c). Specifically, the Third Circuit agreed with the Secretary that, because the provider had not previously received Medicare

reimbursement for those services, it was appropriate to infer that the costs of those services must have been paid using funds provided by other sources in the community. See *Thomas Jefferson* Pet. App. 17a-18a. The court stated that the "universe of community support" could include not only the provider's affiliated medical school (which had absorbed the cost of the services in *Thomas Jefferson*, see *id.* at 19a, 22a), but also other funds received by the provider or its affiliates from outside sources that were then used to support educational activities. See *id.* at 18a ("community support" can consist of "tuition and fees, Federal appropriations, Federal grants and contracts, private gifts, grants and contracts, endowment income, investment income and other income").

Thus, even if the court in *Thomas Jefferson* had rejected the Secretary's interpretation of the anti-redistribution clause of the regulation, the provider hospital could still have been barred from receiving Medicare reimbursement for those costs because the costs would have been paid by the provider (or by the medical school) out of funds received from the community. And even if the Third Circuit had found in *Thomas Jefferson* that the newly claimed GME-related costs had previously been absorbed by the provider, rather than by the medical school, the community support principle might still have barred Medicare reimbursement to the provider for those costs, since a provider presumably must rely on such other sources of funds to cover expenses that are not reimbursed by Medicare.

In light of the foregoing analysis, if this Court grants the petition for a writ of certiorari in *Thomas*

Jefferson, it will almost certainly be appropriate to reverse and remand the court of appeals' decision in this case for further consideration regardless of how *Thomas Jefferson* is resolved. If the judgment of the Third Circuit in *Thomas Jefferson* is affirmed on the redistribution issue, the decision in this case will have to be remanded for a definitive determination of whether some portion of the costs claimed by the provider were in fact previously absorbed by the provider's affiliated medical school. To the extent the medical school had paid those costs, the provider would not be entitled to reimbursement, because the claimed amounts would represent "increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

If, in contrast, this Court disagrees with the Third Circuit's resolution of the redistribution issue and concludes that reimbursement of the GME-related costs in that case would not represent a forbidden shift of costs from an educational unit to a patient care unit, the Court presumably would then consider the court of appeals' alternative "community support" rationale for holding that the provider was not entitled to reimbursement for GME-related overhead costs in that case. If this Court then upholds the Third Circuit's determination that reimbursement should be denied on the alternative ground that, under the regulation, the claimed costs had previously been paid by the "community," see *Thomas Jefferson* Pet. App. 17a-20a, it would be appropriate to vacate the decision in the instant case and remand for the Sixth Circuit to determine whether the community support principle remains as an independent obstacle to

reimbursement of the costs claimed by respondent.[4] In sum, since any decision in *Thomas Jefferson* will almost certainly have some bearing on the proper resolution of the instant case, the petition in this case should be held pending this Court's disposition of the petition in *Thomas Jefferson.*

For the foregoing reasons and those previously stated in the petition, the petition for a writ of certiorari should be held and disposed of in light of the Court's disposition of *Thomas Jefferson University, d/b/a Thomas Jefferson University Hospital* v. *Shalala*, petition for certiorari pending, No. 93-120.

Respectfully submitted.

DREW S. DAYS, III
Solicitor General

DECEMBER 1993

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[4] Respondent contends (Br. in Opp. 7) that there is no "square conflict" between the Sixth Circuit's decision in this case and the Third Circuit's decision in *Thomas Jefferson* because the court of appeals here did not separately discuss the community support principle, but based its holding solely on its interpretation of the anti-redistribution clause of the regulation. Respondent's reasoning is flawed. Not only is there a square conflict between the two decisions on the proper interpretation of the language in the regulation forbidding the shifting of costs from an educational to a patient care institution, but, as already explained, this Court's resolution of the community support issue would also shed light on the proper meaning of the regulation in its entirety and the proper application of the regulation in this case.